**U.S. Department of Labor**

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**Issue date: 23Jul2001**

**CASE NO.: 2000-BLA-00591**

In the Matter of:

**MAXINE B. NOGOSKY,**
**WIDOW OF FRANK C. NOGOSKY**
Claimant

v.

**U.S. STEEL MINING COMPANY**
Employer

and

**DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS, UNITED STATES DEPARTMENT OF LABOR**
Party-in-Interest

APPEARANCES:

Maxine B. Nogosky, **pro se**
For the Claimant

BEFORE: **DAVID W. DI NARDI**
Administrative Law Judge

## DECISION AND ORDER - DENYING BENEFITS

This survivor's claim arises under Title IV of the Federal Coal Mine Health and Safety Act of 1969, as amended, 30 U.S.C. Section 901 **et seq.**, (hereinafter the "Act") and the implementing regulations which are located in Title 20 of the Code of Federal Regulations. Regulation numbers in this Decision and Order are contained in that Title.

Under the Act, benefits are awarded to coal miners who are totally disabled within the meaning of the Act due to pneumoconiosis or to qualifying survivors. Pneumoconiosis, commonly known as black lung, is a dust disease of the lungs resulting from coal dust inhalation.

## PROCEDURAL HISTORY

Frank Chester Nogosky, the deceased miner, originally filed a claim with the Social Security Administration for black lung benefits on October 27, 1970. (DX 17-1) His claim was initially denied on March 1, 1971 and denied again on reconsideration, on July 20, 1973, on the basis that the miner had failed to establish that he had pneumoconiosis. The claim was then referred to the Bureau of Hearings and Appeals and, on May 14, 1975, Administrative Law Judge Herman Platt denied benefits, again finding that Mr. Nogosky did not suffer from pneumoconiosis or any other chronic pulmonary disease. (DX 17-38) Because this claim was denied prior to March 1, 1978, Claimant exercised his right to elect review of his claim under Section 435 of the Act. However, following consideration of the claim under the new regulations, it was again determined that the miner was not eligible for black lung benefits and his claim was referred to the Department of Labor for reconsideration. (DX 17-40)

The Department of Labor, Office of Workers' Compensation Programs (OWCP), denied the miner's claim on August 12, 1981. (DX 17-53) Mr. Nogosky then filed a second claim for benefits with the Department of Labor on September 20, 1993, which was finally denied on March 10, 1994. (DX 18-1, 18-12) The miner filed a request for modification on May 8, 1995, but because it was filed more than one year after the denial, the request was denied as untimely. (DX 18-17) Mr. Nogosky then filed a request for a formal hearing on March 18, 1996 and the claim was transferred to the Department of Labor Office of Administrative Law Judges.

Frank Nogosky died on September 11, 1996. Maxine Nogosky (the "Claimant" herein), filed a claim for survivor's benefits under the Act on November 8, 1996. (DX 1) This claim was initially denied by the District Director, OWCP on December 20, 1996 and Claimant requested reconsideration on January 9, 1997. (DX 8, 9) After considering additional evidence submitted in connection with the survivor's claim, OWCP again denied the claim, which Claimant appealed on April 28, 1997. (DX 13, 14) On May 28, 1997, OWCP denied Claimant's appeal of the decision on reconsideration and the claim was referred to the Office of Administrative Law Judges upon Claimant's request for a formal

hearing filed on June 10, 1997. (DX 19) On September 22, 1998, Administrative Law Judge Pamela Lakes Wood remanded the claim back to OWCP for further development of the medical evidence. (DX 22) In particular, Judge Wood noted that the regulatory criteria under Section 718.201 had not been addressed by any of the reviewing physicians of record.

On remand, OWCP Senior Claims Examiner Edgar B. Farris issued a Proposed Decision and Order Following Remand, in which he found that the evidence did not support a finding that Mr. Nogosky suffered from coal workers' pneumoconiosis and therefore could not have hastened his death in any way. (DX 28) On January 11, 2000, Claimant requested a hearing before the Office of Administrative Law Judges and the case was originally set for hearing on August 11, 2000 before Administrative Law Judge Richard T. Stansell-Gamm. Upon the Claimant's request, the hearing was continued and the matter was reassigned to the undersigned, who then set the hearing for March 8, 2001. Counsel for the responsible operator notified the Court in correspondence dated January 5, 2001, that the operator would not appear at the hearing and requested that a decision be issued upon the existing record, together with Claimant's hearing testimony. Finally, after it was determined that the application of the new Black Lung regulations would not affect the outcome of this case, the hearing went forward as scheduled, at which time all parties were given the opportunity to present evidence and oral arguments. This decision is being rendered after having given full consideration to the entire record.[1]

**ISSUES**

(1) Whether the evidence is sufficient to establish the existence of pneumoconiosis pursuant to 20 C.F.R. § 718.202(a)(1) - (4);

(2) If so, whether the miner's pneumoconiosis arose out of his coal mine employment pursuant to 20 C.F.R. § 718.203(c); and

(3) If so, whether the evidence is sufficient to establish

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[1]The following references will be used herein: TR for the official hearing transcript, ALJ EX for an exhibit offered by this Administrative Law Judge, CX for Claimant's exhibit, DX for a Director's exhibit, and RX for an exhibit offered by the Employer.

that the miner's death was due to pneumoconiosis pursuant to 20 C.F.R. § 718.205(c).

## APPLICABLE REGULATIONS

Claimant filed her current application for survivor's benefits on November 8, 1996. (DX 1) Because the permanent Part 718 regulations became effective after March 31, 1980, the merits of this claim must be considered pursuant to those regulations. This case arises within the appellate jurisdiction of the United States Court of Appeals for the Fourth Circuit.

## SUMMARY OF THE EVIDENCE

### X-Ray Evidence

The record contains 18 X-rays and a total of 25 readings, by interpreters of varying degrees of expertise. Twenty-three of the readings were negative for coal workers' pneumoconiosis (CWP). The remaining two positive readings were of films taken on June 8, 1981 and November 12 1971. With respect to the 1981 film, Dr. Joseph Covelli's interpretation was type p rounded opacities with a profusion of 1/2 in the mid and lower zones of both lungs, and type s irregular opacities with a profusion of 1/1 in the same zones. (DX 17-50) However, this same film was also read by Dr. Nicholas Sargent, who concluded that this X-ray was completely negative for the presence of CWP. As between these two physicians, Dr. Sargent is both a B reader and Board-Certified Radiologist, whereas Dr. Covelli holds neither of these professional qualifications. I therefore find that the June 8, 1981 chest X-ray does not constitute substantial, probative evidence that the miner suffered from CWP. Turning now to the 1971 film, which was read by five different physicians, only one (Dr. Weisman) found it positive for CWP. Although Dr. Weisman is a Board-Certified Radiologist, there were three others, with identical certification who are also B readers, who read this film as entirely negative for pneumoconiosis. I properly accord the greatest probative weight to the readings conducted by those physicians with superior professional qualifications and likewise find this film does not support a finding of pneumoconiosis in this miner. Therefore, in conclusion, the x-ray evidence of record does not establish that Mr. Nogosky suffered from pneumoconiosis. Claimant may still prevail, however, via medical opinion and/or autopsy evidence, which I shall now discuss.

**Medical Opinion/Autopsy Evidence**

The record contains numerous medical records, including treatment notes, consultation reports, surgical reports, laboratory data and correspondence, as summarized below.

**Edmund Roll, M.D.**

On May 18, 1973, Dr. Roll sent a medical report to the Disability Determination Section in Jacksonville, Florida, stating that he had evaluated Mr. Nogosky for Black Lung disease on May 17, 1973. (DX 17-33) The miner reported a 35-year history of coal mine employment, ending in 1970. He also indicated on a questionnaire that he has had a productive morning cough for 5-6 years, shortness of breath on slight exertion, some wheezing when lying down and chest pain for 5-6 years as well. He reported that he began smoking cigarettes at age 15-16, approximately 1½ packs per day, quitting at about the age of 45 and switching to a pipe. He also indicated a history of hypertension. On physical examination, the lungs were essentially clear with some end-expiratory wheezes heard; however, Dr. Roll reviewed a copy of a chest x-ray (dated May 17, 1973), which he interpreted as having the "presence of interstitial fibrosis, which could conceivably be pneumoconiosis, but is not typical." **Id.** at 2. He also reviewed an EKG, which he stated was "questionably abnormal." **Id.** at 3. On the basis of these findings, he concluded that the patient had moderately reduced function and that the chest x-ray "suggested emphysema with the possibility of some interstitial fibrosis that possibly could be from pneumoconiosis, but is not characteristic of it." **Id.** The record reflects that Dr. Roll listed his medical specialties as Pulmonary Diseases and Internal Medicine, however, he holds no Board-Certification in either specialty. (DX 17-34)

**Leonard Gardberg, M.D.**

Dr. Gardberg admitted Mr. Nogosky to Florida Hospital on June 25, 1975 for acute gastroenteritis and chest pain. (DX 17-47) It is not clear whether Dr. Gardberg was the miner's treating physician or an attending physician in the emergency room. He examined the miner and took his history, noting that his occupation was as a janitor and "smokes a great number of tobacco bowls per day with inhaling" but denied any shortness of breath or coughing. Upon physical examination, his lungs were

clear and his EKG was normal. He was subsequently discharged on June 27, 1975.

**Allan M. Goldman, M.D.**

The record contains the medical report of Dr. Goldman, dated March 14, 1980, which indicates that he examined Mr. Nogosky at the South Florida College of Medicine Pulmonary Disease Clinic on March 10, 1980, at the Employer's request. (DX 17-49) He reported a 35-year history of working in the coal mines "in various underground occupations," retiring on October 4, 1968. The miner related to Dr. Goldman that he did not have any significant respiratory symptoms at the time of his retirement. He also stated that he smoked 1 to 2 packs of cigarettes per day for 25 years, but quit in 1965 and has smoked about 4 pipes per day for the last 15 years. He described a chronic productive cough in the morning, afternoon and night, persisting for the past 12 to 15 years, as well as "wheezing, whistling and tightness in his chest a few times a week...brought on or made worse by warm weather." In addition, the miner complained of shortness of breath with slight exertion. In addition to a physical examination, Dr. Goldman performed pulmonary function studies, a chest x-ray, EKG, and arterial blood gas analysis, both at rest and post-exercise. The physical exam was unremarkable and he characterized the chest x-ray as revealing "dirty looking lung fields." None of the laboratory data supported a finding of total disability. Based upon this information, Dr. Goldman made the following conclusions:

> Although this patient has symptoms of chronic bronchitis, this apparently is simple chronic bronchitis with no respiratory impairment as determined by spirometry and arterial blood gases at rest and after exercise. Therefore, I believe he has symptomatic chronic bronchitis related to past cigarette abuse, possible (sic) also made worse by coal mining but because there is no respiratory impairment on pulmonary function testing nor any significant abnormalities on chest x-ray, I do not consider him impaired or disabled in any way.

**Id.**

**Kenneth F. Dutt, M.D.**

There are patient progress notes dating from June of 1988 to October, 1993. (DX 18) However, the notes are entirely handwritten and difficult to decipher. Where legible, the notes appear to relate solely to the miner's cardiac condition and there is no mention of his coal mine work or any respiratory or pulmonary condition arising therefrom. These records also contain several typewritten notes from various physicians (Drs. Vyas, Ridler and Kolosky) who apparently saw the miner for follow-up visits, although it is not clear from these notes where they took place, nor the qualifications of these doctors. The reports indicate the miner was having chest pain, angina and hypertension. Once again, the focus of these records is on the miner's cardiac status, with no mention of his coal mine employment, his smoking history, or any non-cardiac related condition, other than anemia, which apparently was diagnosed prior to his macroglobulinemia.

**Vasundhara Iyengar, M.D.**

The record includes treatment notes from Dr. Iyengar, dated from June of 1992 to July of 1996. (DX 24) These records indicate that the miner had a history of Waldenstrom's Macroglobulinemia (described as a rare chronic cancer), diagnosed after a bone marrow biopsy in 1992. In a report dated September 29, 1993, Dr. Iyengar made the following impressions, following the miner's admission to Orlando Regional Medical Center on September 27, 1993, "with severe brady episodes associated with syncopal episodes....":

> 1. Waldenstrom macroglobulinemia, mild and essentially asymptomatic as per last check up one or two months ago.
>
> 2. Atherosclerotic heart disease with congestive heart failure, severe, contributing to most of patient's current problems.

(DX 24) The doctor's narrative also indicates that the miner suffered a heart attack earlier in the year, which precipitated a worsening of his atherosclerotic heart disease. At the time of his heart attack, the miner underwent a coronary artery bypass graft, at which time he was diagnosed with valvular heart disease with aortic insufficiency. Since his surgery, he also suffered from pericarditis and pericardial effusion, which the doctor noted had been treated and controlled, however, Mr.

Nogosky continued to have "severe symptoms of congestive heart failure with orthopnea, dyspnea, and paroxysmal nocturnal dyspnea." **Id.** Furthermore, Dr. Iyengar noted that, "in the immediate postoperative period [he] must have had [an] ischemic central nervous system event because since the recovery from his heart surgery, the patient's mental status has changed dramatically." **Id.** On physical examination, the miner's lungs were "[c]lear to auscultation on percussion," however his cardiovascular system was "[r]emarkable for grade 2/6 pansystolic murmur as well as an early diastolic murmur consistent with aortic insufficiency murmur over the base of the heart." **Id.** Dr. Iyengar cautioned that he felt the treatment for macroglobulinemia would exacerbate Mr. Nogosky's congestive heart failure and worsen his renal functions; however, the miner was "willing to take the risk and receive the treatment." (DX 24) The miner was hospitalized again on or about October 14, 1993 and on October 16, 1993, Dr. Iyengar authored another report, wherein he stated that the treatment for macroglobulinemia, which includes steroids, "has contributed to his worsening of cardiac status at least in part." **Id.** The remainder of Dr. Iyengar's reports, dated March 10, 1994, November 7, 1994, November 16, 1994, April 14, 1995, May 4, 1996 and July 22, 1996, all focus on Mr. Nogosky's worsening cardiac status and do not reveal any abnormality of his respiratory system, other than increasing shortness of breath attributed solely to his coronary artery disease and severe congestive heart failure. Over this period of time, the miner was hospitalized on several occasions for worsening of his symptoms and underwent repeated bone marrow aspiration biopsies, EKG's, and various blood tests to monitor the progression of his multiple medical conditions.

**Joseph H. Boyer, M.D. & Anil Bansal, M.D.**

The record indicates that Dr. Bansal treated the miner from April of 1993 to approximately August of 1996 and referred Mr. Nogosky to Dr. Boyer for coronary bypass surgery in April of 1993. Dr. Boyer's operative report dated April 19, 1993 states that the miner was diagnosed with, **inter alia,** severe triple vessel coronary artery disease, left main coronary artery stenosis and unstable angina. He underwent urgent quadruple bypass surgery, at which time the surgeon noted that Mr. Nogosky "had considerable (sic) more aortic insufficiency than we had expected" and, at one point, "the patient went into ventricular fibrillation and he had to be countershocked." However, the

procedure was completed and Dr. Boyer stated that Mr. Nogosky went to the recovery room in stable condition. During this hospitalization, the miner underwent several chest x-rays, EKG's, blood gas analyses, and other blood tests. He was discharged on April 28, 1993 and Dr. Boyer reported that his hospital course was uneventful. The miner was again hospitalized from May 2 to May 6, 1993 with complaints of chest pain and shortness of breath. Upon examination, Dr. Boyer noted basilar crackles in the right lung and decreased lung sounds on the left. A chest x-ray indicated left pleural effusion and he underwent a therapeutic draining of his left lung as well as aggressive diuretic therapy, with positive results. Dr. Boyer's final diagnoses were as follows:

1. Congestive heart failure.
2. Persistent left pleural effusion.
3. Hypertension.
4. Status post coronary artery bypass graft.
5. History of Waldenstrom disease.
6. History of myocardial infarction.
7. Dental infection.

Mr. Nogosky had his first post-surgery follow-up visit with Dr. Boyer on May 20, 1993. In correspondence to Dr. Bansal, he notes that the miner is no longer complaining of angina, shortness of breath, or cough and that "this seems to be a highly satisfactory result to date...." (DX 27 at 705) On May 26, 1993, Dr. Bansal sent correspondence to Dr. Iyengar, stating that the miner was continuing to do very well recovering from his bypass surgery. (DX 27 at 703) His physical examination of the miner on that date showed the lungs to be clear "with a few inspiratory wheezes which clear with coughing... [and] decreased air entry in the bilateral lower bases." His impressions were shortness of breath "probably related to his chronic obstructive pulmonary disease versus aortic insufficiency" and resolved congestive heart failure and pleural effusion. Dr. Bansal saw Mr. Nogosky for continued follow-up office visits on the following dates: July 14, 1993, August 11, 1993, September 9, 1993, and September 23, 1993. These records indicate that the miner began complaining of increased shortness of breath when lying flat; however, upon examination, his lungs were clear. An echocardiogram performed on July 14, 1993 revealed abnormal results, indicating "mild systolic dysfunction with moderate aortic insufficiency with some fluttering of the mitral valve." (DX 27 at 646)

On September 27, 1993, Mr. Nogosky was admitted to Orlando Regional Medical Center by Dr. Bansal, for severe bradyarrhythmia, severe dizziness and nausea, ans generalized weakness. His lungs were clear upon examination and he was diagnosed with hyperkalemia (high potassium) due to increasing renal insufficiency and severe dizziness due to bradycardia (slow heart rate), also due to sick sinus syndrome. He went home on September 30, 1993. On October 3, 1993, he was readmitted by Dr. Iyengar, this time for a bone marrow biopsy to evaluate the status of his macroglobulinemia. He also underwent a right and left heart catheterization and angiography on October 15, 1993, which revealed severe coronary artery disease and severe aortic insufficiency and was considered a high risk candidate for aortic valve replacement. Dr. Bansal continued to see the miner for office visits on October 20 and November 30, 1993, treating him aggressively with medication. However, he continued to deteriorate and, on March 17, 1994, he underwent the aortic valve replacement surgery, performed by Dr. Boyer. (DX 27 at 663-666) In his operative report, the surgeon noted that the miner tolerated the procedure well, without incident. (DX 27 at 663-4, 689) He was seen in follow-up by Dr. Bansal on April 5, 1994, who noted, "he has done quite well in spite of his multitude of medical problems." (DX 27 at 688) On June 21, 1994, the miner saw Dr. Bansal again, this time complaining of "a recent productive cough." Upon physical examination, his lungs were clear to auscultation and Dr. Bansal subsequently diagnosed an upper respiratory infection, addressed by antibiotic treatment. On July 5, 1994, Dr. Bansal noted that the treatment effectively resolved his upper respiratory symptoms and the miner continued to do well overall and remained asymptomatic through his examination on April 4, 1995.

On April 8, 1995, Dr. Bansal admitted Mr. Nogosky for unsteady gait and complaints of falling. (DX 25) The physician noted that the miner "smokes 40 packs per year." However, the physical exam was unremarkable and it appears from the record that Dr. Bansal next saw the miner on September 18, 1995, noting that he continued to do well with no complaints of shortness of breath or chest pain. The next recorded office visit, dated March 5, 1996, discloses that Mr. Nogosky began complaining of shortness of breath and chest discomfort with periods of loss of balance. (DX 27 at 675-6) Dr. Bansal ordered an echocardiogram and tests of his valve function, the results of which were described as "severely abnormal." (DX 27 at 652) Cardiac catheterization was recommended, which he underwent on March 22, 1996 and the results of this procedure indicated severe coronary

artery disease with significant blockage in three arteries. (DX 27 at 657-660) His next office visit with Dr. Bansal on April 16, 1995, bespeaks of the miner becoming increasingly frail, with more frequent episodes of falling, shortness of breath and chest pain. The miner was then admitted for observation on April 27, 1996 after referral from a home nurse, who reported falling, productive cough with brown sputum, weakness and complaints of lower back pain. (DX 25) By the time of his visit to Dr. Bansal on July 16, 1995, he was still suffering severe angina, for which the doctor recommended non-surgical coronary stenting and to which the miner consented. He was then admitted for three days on July 22, 1996 and the procedure yielded good results. Dr. Bansal discussed with the patient and his family the benefits of moving the miner to an extended care facility, given his frequent falling.

**Ganesh Akula, M.D.**

The record contains two references to examinations of the miner performed by Dr. Akula at the Orlando Regional Medical Center on March 11 and May 23, 1994, apparently on referral from Drs. Bansal and Iyengar. (DX 7, DX 27 at 325-6) The first examination report indicates that Mr. Nogosky was being evaluated for shortness of breath and wheezing. (DX 27 at 325) Dr. Akula took the miner's medical and social histories, conducted a physical examination, took a chest x-ray, and ordered routine blood work. He noted that Mr. Nogosky was 76 years of age with a history of atherosclerotic heart disease, status post coronary artery bypass graft times four, congestive heart failure, valvular heart disease and macroglobulinemia (on chemotherapy). At this time, the miner denied a history of chest pain, cough, expectoration, fever, chills or hemoptysis. He reported a smoking history of two packs per day for 30 years, quitting approximately ten years prior. The only reference to coal mine employment was the following statement: "The patient worked in the coal mines for several years, but he was never told to have any black lung." **Id.**

On physical examination, the doctor noted "[b]ilateral diffuse rales below the infrascapular region" of the lungs. He described the chest x-ray as revealing "borderline cardiomegaly, with bilateral pulmonary edema." After reviewing the laboratory data from the blood tests, Dr. Akula made the following impressions:

“ 1. Pulmonary edema/congestive heart failure.
2. Shortness of breath and wheezing, most probably secondary to congestive heart failure, however, underlying obstructive lung disease cannot be ruled out (the patient has a history of smoking about 60-pack years).
3. Anemia, due to chronic disease.
4. History of macroglobulinemia.
5. Valvular heart disease (aortic incompetence).
6. Mild prerenal azotemia.”

**Id.** A very brief report accompanied the May 23, 1994 examination, wherein Dr. Akula performed a physical examination and made the following assessments: (1) Status post AVR; (2) Congestive heart failure, history of ASHD; (3) COPD; and (4) Macroglobulinemia. (DX 7) He concluded by recommending that the miner be equipped with home oxygen service, with follow-up in 6 to 8 weeks. **Id.**

**Joseph L. Covelli, M.D.**

Dr. Covelli evaluated the miner for coal workers’ pneumoconiosis, his report dated June 8, 1981. (DX 17-50) Mr. Nogosky reported working in the mines from 1936 to 1981. His current complaints were productive cough (15 - 18 years), nocturnal wheezing (11 - 12 years), dyspnea on exertion (20 years) and chest pain for approximately 5 years. He reported a smoking history of one pack per day for 20 years, quitting in 1965 and 3 pipes per day since that time.

On physical examination, Dr. Covelli noted occasional expiratory rhonchi over both lungs posteriorly and interpreted a chest x-ray taken on June 8, 1981 as positive for CWP. In the “diagnosis” portion of the report, Dr. Covelli wrote: “1. H[istory] coal dust exposure, 2. Chronic bronchitis.” In answer to the question ‘in your opinion is the diagnosed condition related to dust exposure in the patient’s coal mine employment?” the doctor checked-off “yes” and wrote, “CXR (chest x-ray) does reveal evidence of a pneumoconiotic process over both mid to lower lung fields. There is a very mild obstructive ventilatory pattern despite discontinuation of tobacco in 1965. As such, I feel his symptoms of dyspnea are related to his coal dust exposure.” **Id.**

**Luis A. Guarda, M.D.**

Following the miner's death at home on September 11, 1996, an autopsy was performed by Dr. Guarda on September 13, 1996. (DX 6) He made the following observations upon gross examination:

"SEROSAL CAVITY OF MEDIASTINUM: There is no fluid in the pleural, pericardial and peritoneal cavities. Some fibrous adhesions, especially anteriorly, are identified in both pleural cavities and the pericardium, the result of previous heart surgery. Otherwise the mediastinum is unremarkable.

"CARDIOVASCULAR SYSTEM: There is extensive atherosclerosis of te aorta, which becomes more pronounced distally, in the abdominal aorta; in fact distally, the aorta is tortuous and rigid due to excessive calcifications. The vena cava are normal...

RESPIRATORY SYSTEM: The trachea and major bronchi are patent and are lined by a slightly congested mucosa; there is minimal amount of purulent material covering the trachea... The pleural surfaces of both lungs show mild anthracosis. Palpation of the lungs reveals no masses. Examination of the intrapulmonary bronchial tree reveal that it is patent with no significant abnormalities. Sectioning through the lungs reveals normal lung parenchyma, with the exception of congestion of the lower lung lobes. There are no visible or palpable nodules, granulomas, cavities or masses..."

Dr. Guarda then performed a microscopic examination of specimens collected during the autopsy, the relevant observations reported below:

"HEART: The myocardium shows extensive areas of fibrous replacement where the native myocardial fibrous have been replaced by scars of fibrous tissue, a phenomenon that is more pronounced in the posterior wall of the left ventricle and in multiple foci subendocardially. The right ventricle is unremarkable.

"CORONARY ARTERIES: The main trunk of the left coronary artery shows luminal narrowing due to atherosclerosis, with a residual lumen that is 50% of normal.

"Left anterior descending coronary artery: this is a relatively small vessel with narrowing of its lumen due to atherosclerosis, with a residual lumen that is 50-60% of normal size. The left internal mammary graft to this vessel could not be identified

and was probably lost at the time of dissection due to the dense adhesion of pericardium and epicardium. The left circumflex artery is patent and has a large branch that is identified as one big obtuse marginal branch, which has distal atherosclerotic involvement of more than 70% with a graft that is patent and a patent anastomosis at a site of severe atherosclerotic involvement. The first diagonal branch of the left anterior descending artery is proximally composed of two large vessels that show atherosclerotic involvement with luminal narrowing of more than 50%. There is a patent graft to one of these branches; focally, the atherosclerotic narrowing of the artery is up to 70%.

"Right coronary artery shows severe multifocal atherosclerotic involvement, with areas that are more than 80% narrowed; there is a patent venous graft with a patent anastomosis.

"LUNGS: The lungs show mild focal anthracosis, but no evidences of pneumoconiosis. There are focal areas of atelectasis throughout the lung sections, most of which are probably postmortem induced. There are congestion and edema in the lower lung lobes with microscopic foci of early acute pneumonia in the left lower lung lobe.

"MEDIASTINAL LYMPH NODES: Anthracosis, with one lymph node revealing an old hyalinized granuloma."

Based upon these findings, Dr. Guarda made the following

"FINAL ANATOMIC DIAGNOSIS

1. GENERALIZED ATHEROSCLEROSIS WITH PROMINENT AORTIC AND CORONARY ARTERY INVOLVEMENT...
2. STATUS POST REMOTE CORONARY ARTERY BYPASS SURGERY.
3. MILD PULMONARY ANTHRACOSIS.
4. MILD ANTHRACOSIS OF MEDIASTINAL LYMPH NODES.
5. EDEMA AND CONGESTION OF LOWER LUNG LOBES.
6. FOCAL ACUTE PNEUMONIC CHANGES IN LEFT LOWER LUNG LOBE...
7. BILATERAL ARTERIOLONEPHROSCLEROSIS...."

(DX 6) On November 12, 1996, Dr. Guarda issued a brief addendum to his autopsy report, wherein he addressed the patient's long-standing diagnosis of macroglobulinemia. (DX 12) There was no discussion in this addendum relating the miner's pulmonary or respiratory condition. Dr. Guarda's curriculum vitae indicates

that he is Board-Certified in Anatomic and Clinical Pathology and Cytopathology and has served in the Department of Pathology at Florida Hospital, Orlando, since 1983. (DX 6)

On January 29, 1999, Dr. Guarda wrote a brief letter to the Senior Claims Examiner, which stated as follows:

> "Dear Mr. Farris,
>
> I have received your letter dated January 20, 1999 and this letter is to clarify my statements in the above referenced autopsy. The designation of anthracosis in the list of diagnosis (sic) is a term I used to denote anthracotic pigmentation. In my opinion, there is no pneumoconiosis. However, if you feel that the slides on this case need to be reviewed by another expert I will make them available to you."

(DX 26)

**Joshua A. Perper, M.D.**

The last medical opinion appearing in the record is that of Dr. Perper, who is Board-Certified in Anatomical and Surgical Pathology, as well as Forensic Pathology. (DX 15) He submitted two reports, dated May 9, 1997 and November 29, 1999. (DX 15, 27) The first report indicates that he reviewed Dr. Guarda's autopsy report, 43 microscopic slides obtained at autopsy and the miner's Death Certificate. (DX 15) Dr. Perper summarized his findings after conducting his own microscopic examination of the autopsy slides, stating as follows:

"Lungs
- Pleural anthracotic pigmentation, focal slight, with small numbers of small birefringent silica crystals. In a few places there are focal, slight fibro-anthracotic thickenings of the pleura, with few silica crystals.
- Slight, focal, sparse anthracotic pigmentation, particularly peri-vascular and peri-bronchial
- Moderate to marked centri-lobular chronic emphysema with focal interstitial fibrosis and chronic inflammatory infiltrates.
- A solitary septic embolus built of closely packed polys was seen in a pulmonary vessel.
- Congestion and edema, focally with extravasation of red blood cells.

- In an occasional bronchus and focally on a few alveoli, macrophages with brown-yellow pigment are present.
- In one place an area of fibrosis, chronic inflammation and small empty circular spaces consistent with lipids, suggestive of a focus of lipid pneumonia aspiration.

“Lymph nodes:
- Sections of lymph nodes with variable degrees of fibro-anthracosis, minimal to moderate. The sections with moderate fibro-anthracosis contain numerous birefringent silica crystals.
- One of the lymph node sections contains a silicotic hyaline nodule surrounded by fibrous tissue with anthracotic pigmentation, and containing small numbers of silica crystals.

“Heart:
- Marked, patchy, transmural, focal scarring in one slide (Lvp)
- Other myocardial sections show slight to moderate, focal myocardial fibrosis.

“Coronary arteries:
-Moderate to marked arteriosclerosis with calcifications and patent lumen.

“Other pertinent microscopic findings included: passive congestion of liver and spleen, slight arteriolo-nephrosclerosis with occasional lymphoid infiltrates, prostatic hypertrophy and a hyperplastic bone marrow.

“Microscopic diagnoses:
- Moderate to marked coronary arteriosclerosis
- Myocardial infarction old, trans-mural, patchy pattern
- Focal myocardial fibrosis, moderate
- Chronic emphysema of lungs, marked with interstitial fibrosis
- Slight, sparse macular anthracosis of lungs
- Pneumoconiosis of thoracic lymph nodes, slight, with fibro-anthracosis and silica crystals, and isolated fibro-anthracotic micro-nodule.
- Focus of lipoid pneumonia
- Arteriolo-nephrosclerosis, slight
- Passive congestion of liver and spleen
- Benign hyperplasia of prostate
- Hyperplastic bone marrow”

(DX 15 at 4-5)

Dr. Perper then asked and answered, the following pertinent

questions:

“Medico-legal questions

**“1. What was Mr. Nogoski’s (sic) cause of death?**
No medical history was provided, except for the implicit history of macroglobulinemia listed in the death certificate as a cause of death. However based on the gross autopsy findings and the microscopic findings evaluated and confirmed by the current reviewer, it is most likely that the cause of death was mechanical heart failure or a cardiac arrhthmia (sic) secondary to the arteriosclerotic and valvular heart disease, with severe myocardial scarring. Severe centri-lobular emphysema had the potential of being a substantial contributory cause of death.

“**2. Were the pulmonary findings at autopsy consistent with any coal workers’ pneumoconiosis of significance?**
The answer is ‘No.’ Only sparse anthracotic macules, less than seen in an urban dweller, were observed in the lungs of Mr. Nogoski (sic). The anthraco-fibrosis of the pleura was slight and non significant, and the fibro-anthracosis of some of the lymph nodes with birefringent silica crystals, and the solitary pneumoconiotic micro-nodule are insufficient to deserve a designation of coal workers’ pneumoconiosis. Obviously, they are a marker of exposure to silica containing coal, but such isolated marker does not reflect a disease entity. It is true that Mr. Nogoski (sic) had evidence of significant chronic centri-lobular emphysema of lung, and this condition has been reported in recent years as a complication of coal workers’ pneumoconiosis. However, his pulmonary pathological profile was definitely insufficient for a diagnosis of pneumoconiosis.

“**Conclusion:** In conclusion it is my professional opinion within a reasonable degree of medical certainty that:

**“1. The most likely cause of death of Mr. Nogoski’s (sic) death was arteriosclerotic and valvular heart disease. Centri-lobular chronic emphysema of lung had the potential of being a contributory cause of death. The total lack of clinical data makes impossible a more definite determination.**

**“2. Mr. Nogoski (sic) had minor and non significant markers of exposure to silica containing coal. However, the gross and microscopic findings of the lungs at autopsy failed to reveal**

**any significant degree of coal workers' pneumoconiosis.**

(**Id.** at 5-6)(Emphasis in original)

Dr. Perper then submitted a supplemental report dated November 29, 1999, wherein he indicated that he had reviewed the entire body of medical evidence on Mr. Nogosky, as well as the decisions and orders of Administrative Law Judges Platt and Wood, the miner's employment records, and other correspondence and filings appearing in the administrative file of this matter. (DX 27) Although this supplemental report is lengthy, at 28 pages, the first 26½ pages are a summarization of the materials reviewed. On Page 26, Dr. Perper then formulated and answered the following

**"Medicolegal questions**

**"1. Did the miner ha[ve] anthracosis on autopsy as opposed to anthracotic pigmentation?**
Mr. Nogosky did not have anthracotic lung disease (anthracosis of lungs). As a mater (sic) of fact, as indicated in my initial report the lung tissue of Mr. Nogosky showed less anthracotic pigmentation than seen in the average urban dweller.
As mentioned in my initial report the findings of the lymph-nodes, did not justify a pulmonary diagnosis of coal workers' pneumoconiosis and were only a marker of exposure to mixed coal mine dust. The function of the lymphatic tissues and lymph nodes is to drain noxious substances from the lungs, and in the case of Mr. Nogosky this drainage was particularly effective, sparing his lungs from developing pneumoconiosis.

**"2. Did the miner ha[ve] pneumoconiosis defined as "any chronic pulmonary disease resulting in respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment?**
The answer is a definite no, as based on the following findings:
- The absence of pulmonary pneumoconiosis and presence of insignificant and mild anthracotic pigmentation of the lung with no fibrosis, and substantiated by gross microscopic autopsy findings.
- The presence of centrilobular emphysema, associated with a history of heavy smoking over many years.
It is true that exposure to coal mine dust with significant pneumoconiosis was reported in recent years to result in centrilobular emphysema of lung and chronic obstructive

pulmonary disease. However, in the case of Mr. Nogosky, the absence of coal workers' pneumoconiosis coupled with the heavy smoking history makes unacceptable even a speculation that the exposure to coal dust per se, resulted in emphysema.
- The voluminous clinical records amply substantiate that the patient's respiratory findings were almost exclusively due to episodes of heart failure on the background of coronary artery disease or aortic insufficiency, (aggravated at times by anemia secondary to Waldenstrom's macroglobulinemia), and not to pulmonary disease. As a matter of fact when the former conditions were ameliorated post medication or surgery, the record specifically mentions clinical improvement with no cough or shortness of breath.
- With the exception of a couple of chest X-Ray readings by two physicians (Dr. Weisman in 1971 and Dr. Roll in 1973) both non-radiologists and non-B Readers, no one of the other interpreters, most of them radiologists and some also B readers, described findings or made a diagnosis of coal workers' pneumoconiosis over the period of documented medical history from 1971 to the time of the patient's death in 1996. On (sic) should emphasize that during the period in question the patient had numerous chest X-Rays done.
- The patient was treated with cardiac medications, diuretics, antihypertensive medications, iron supplements and specific medications for macroglobulinemia, stools softeners, and anti-depressants but <u>not</u> with bronchodilators or other respiratory medications.

**"3. Did the miner's anthracosis or pneumoconiosis (defined as above) cause...contribute to...or hasten...his death?**
The answer is definitely no as the patient did not have pneumoconiosis or any significant anthracotic pigmentation of his lungs.
The cause of death of Mr. Nogosky was heart disease on the background of severe coronary artery disease that required repeated surgery and severe aortic insufficiency that required valvular replacement, processes that were aggravated by anemia related to Waldenstrom's macroglobulinemia.
Centrilobular emphysema of the lungs related to a heavy smoking history might have also contributed to death, although the significance of the contribution is unclear." (DX 27 at 26-27)

Based upon Dr. Perper's thorough review of these materials and the findings outlined above, he made the following conclusions:

**"1. Mr. Nogosky died as a result of heart failure secondary to coronary and valvular disease which was aggravated by anemia secondary to Waldenstrom's macroglobulinemia. Smoking related emphysema might also have contributed to Mr. Nogosky's death.**

**"2. Mr. Nogosky had no evidence of coal workers' pneumoconiosis, anthracotic lung disease, or any other occupational disease related to coal dust exposure.**

**"3. Mr. Nogosky had pulmonary findings of insignificant pulmonary anthracotic pigmentation in association with markers of exposure to mixed coal dust but no pulmonary pneumoconiosis.**

**"4. The death of Mr. Nogosky was not caused, contributed to or hastened by coal workers' pneumoconiosis or any other occupational disease secondary to exposure to coal mine dusts or other dusts."**

(DX 27 at 28)

**Death Certificate**

The miner's death certificate was completed by Dr. Bansal on September 17, 1996. (DX 5) As the immediate cause of death, he listed "congestive heart failure." Then, in the space provided for "conditions, if any, leading to immediate cause," Dr. Bansal listed Waldenstrom's macroglobulinemia, aortic valve replacement, and coronary artery disease.

**Hearing Testimony**

A hearing was held before the undersigned Administrative Law Judge of the United States Department of Labor on March 8, 2001, at which time the testimony of the miner's widow, Maxine Nogosky was taken. Claimant was accompanied by her daughter, Mary Sizemore and a family friend, Betty Skala, who also testified briefly. The parties, having previously notified the Court that the responsible operator would not attend the hearing, agreed to a decision and order on the record, to be perfected by the taking of the Claimant's testimony, which is summarized below.

Claimant testified as follows. She was married to the deceased miner from May of 1950 until his death in September of 1996. He began working in the coal mines when he was still in high school and continued underground mining all his life,

except for 4½ years spent serving in the military during World War II, for a total of approximately 35 years. She stated that they moved to Florida in 1969 to get away from the mines and that her husband had been having problems with his breathing from the time they were married. She also mentioned that he was "hemorrhaging" from his lungs and would periodically need to be taken to the emergency room. He began using portable oxygen in or about 1988 and slept with three pillows to facilitate his breathing. (TR 10-15) he did not have any hobbies, other than watching sports on television, but even this was difficult. He had many episodes of falling and, at one point, broke his back when he tried to go outside to breathe better. Despite being advised to place Mr. Nogosky in a 24-hour nursing care facility, his wife and children cared for him at home until his death. (TR 15-16) She also stated that about a month prior to his death, his nose and ears turned purple from cyanosis and Dr. Bansal placed a stint in his carotid artery to help get blood and oxygen to his brain. (TR 22)

The miner's stepdaughter, Mary Sizemore, also testified, stating that at one point, it became so difficult to care for Mr. Nogosky that her parents came and lived with her temporarily. She stated that she had to buy him a reclining chair because he could not lay flat in bed or he would be struggling to breathe. She also disputed his smoking history, stating "he was not a smoker." (TR 17)

A friend of the family, Ms. Betty Skala, also testified briefly, stating she was called many times to help out at the Nogosky house. She testified, "I went over there three, four times a night to pick this man up." She stated she knew Mr. Nogosky for ten years and never saw him walk across his living room without being short of breath. (TR 20-22)

## DISCUSSION

The findings of fact and conclusions of law that follow are based upon my thorough analysis and review of the entire record, the arguments of the parties, and applicable statutes, regulations and case law. Each document admitted into evidence, although perhaps not mentioned in this decision, has been carefully reviewed and considered.

### Section 718.202(a)(1) - (4): Existence of Pneumoconiosis

This administrative Law Judge has already reviewed the x-ray evidence of record and my findings are set forth, supra. As it has been determined that such evidence is insufficient to establish that Mr. Nogosky suffered from coal workers' pneumoconiosis under Section 718.202(a)(1), I turn now to the alternate methods of proving the existence of pneumoconiosis, provided by subsection (a)(2), which provides that the existence of pneumoconiosis can be established through biopsy or autopsy evidence. 20 C.F.R. § 718.202(a)(2). Autopsy evidence is the most reliable evidence of the existence of pneumoconiosis. **See Terlip v Director, OWCP,** 8 BLR 1-363 (1985); **Griffith v. Director, OWCP,** 19 BLR 1-211 (6th Cir. 1995). However, as the Benefits Review Board has cautioned, mechanical reliance upon the opinion of the autopsy prosector is improper where there is credible, contrary evidence in the record. **See Urgolites v. Bethergy Mines, Inc.,** 17 BLR 1-20 (1992).

Pneumoconiosis is defined as a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. 30 U.S.C. § 902(b) and 20 C.F.R. § 718.201. The definition is not confined to coal workers' pneumoconiosis, but also includes other diseases arising out of coal mine employment, such as anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, progressive massive fibrosis, silicosis, or silicotuberculosis. 20 C.F.R. § 718.201. The term 'arising out of coal mine employment' is defined as including any chronic pulmonary disease resulting in respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment. This broad definition effectively allows for the compensation of miners suffering from a variety of respiratory problems that may bear a relationship to their employment in the coal mines. **Robinson v. Pickands Mather & Co./Leslie Coal Co. & Director, OWCP,** 14 BLR 2-68 (CA4 1990) at 2-78, 914 F.2d 35 (4th Cir. 1990) citing, **Rose v. Clinchfield Coal Co.,** 614 F. 2d 936, 938 (4th Cir. 1980).

In the case at bar, there is no biopsy evidence other than the bone marrow biopsies conducted in relation to Mr. Nogosky's macroglobulinemia. Therefore, I turn now to the autopsy evidence to determine its sufficiency to establish the existence of pneumoconiosis under the standard enunciated above. The reports and correspondence of the autopsy prosector, Dr. Guarda, have been summarized in detail. Based upon a thorough review of

this evidence, I find and conclude that it does not establish that Mr. Nogosky suffered from coal workers' pneumoconiosis at the time of his death. The only evidence of dust-related illness mentioned in Dr. Guarda's autopsy report is where he referenced finding "mild anthracosis" in both lungs upon both gross and microscopic examination. However, Dr. Guarda clarified his opinion in this regard, stating in his January 29, 1999 correspondence that his finding of mild pulmonary anthracosis was his way of describing anthracotic pigmentation. He went on to state that he did not find any pneumoconiosis. It is important to note that, if Dr. Guarda made these comments without regard for the broader, legal definition of CWP, then it could be argued that his finding of anthracosis equates with a finding of pneumoconiosis in this individual. Anthracosis supports a finding of pneumoconiosis as it is defined in the regulations. 20 C.F.R. § 718.201; **Youghiogeny & Ohio Coal Co. v. Milliken,** 886 F.2d 195, 197 (6th Cir. 1989); **Bumgardner v. The Ohio Valley Coal Co.,** 187 F.3d 634, 1999 WL 486402, **4 (6th Cir. 1999)(unpublished) (anthracosis is a form of black lung); **Daugherty v. Dean Jones Coal Co.,** 895 F.2d 130, 132 (4th Cir. 1989); **Bueno v. Director, OWCP,** 7 BLR 1-337, 1-340 (1984); **Dobrosky v. Director, OWCP,** 4 BLR 1-680 (1982); **Peabody Coal Co. v. Shonk,** 906 F.2d 264, 268 (7th Cir. 1990); **Consolidation Coal Co. v. Smith,** 837 F.2d 321, 322 n. 2 (8th Cir. 1988). However, in the case at bar, Dr. Guarda explained his diagnosis of mild anthracosis as equivalent to merely a finding of anthracotic pigmentation. Therefore, because the regulations state that an autopsy finding of anthracotic pigmentation shall not be sufficient, by itself, to establish the existence of pneumoconiosis, this evidence fails to support such a finding here. In this regard, **See** 20 C.F.R. §§ 718.202(a)(2).

Dr. Perper, who reviewed the autopsy report, conducted an independent microscopic examination of the autopsy slides, and reviewed the entire medical record in this case, agreed that none of the autopsy findings were consistent with a diagnosis of CWP, noting that he saw only "sparse anthracotic macules, less than [that] seen in an urban dweller." Furthermore, although Dr. Perper diagnosed severe centri-lobular emphysema, which was not among the diagnoses made by Dr. Guarda, he did not link this condition to coal dust exposure, stating "his pulmonary pathological profile was definitely insufficient for a diagnosis of pneumoconiosis." Moreover, after being given the opportunity to review the entire medical record, Dr. Perper remained steadfast in his opinion that the miner did not suffer from CWP

prior to his death. Dr. Perper discussed in great detail his rationale for these findings and, of particular import, were the statements made in his second report dated November 29, 1999, after reviewing all of the medical evidence. He stated therein that the emphysema observed in the lungs was, in his opinion, attributable to the miner's heavy smoking history and continued tobacco abuse through pipe smoking, with inhalation, which continued after he quit cigarette smoking. Of particular import is the fact that Dr. Perper was unwilling to state unequivocally that this smoking-related emphysema was a cause of the miner's death; he merely stated that it had the *potential* to contribute to death. Given Dr. Perper's impressive professional qualifications, I find it telling that he stopped short of including the emphysema among the causes of death in this case, especially given his finding that this was a severe form of the disease. Dr. Perper recognized that this particular type of emphysema is often associated with advanced stages of pneumoconiosis, but noted that this could not have been the case with Mr. Nogosky, as the lungs themselves had very little evidence of anthracotic pigmentation and no other evidence of CWP at all.

Thus, both pathologists, possessing roughly equivalent qualifications, agreed that the autopsy failed to produce sufficient data to support a diagnosis of CWP or any other dust-related disease. As a result, the autopsy evidence is insufficient to establish that Mr. Nogosky suffered from legal pneumoconiosis pursuant to 20 C.F.R. § 718.202(a)(2). Furthermore, Claimant cannot rely upon the presumptions set forth at Sections 718.304, 305 or 306 to prove that Mr. Nogosky had CWP during his lifetime under 20 C.F.R. § 718.202(a)(3). First, the chest x-ray evidence does not support a finding of complicated pneumoconiosis as required for invocation of the Section 718.304 presumption; second, since the survivor's claim was filed after January 1, 1982, the Section 718.305 presumption is unavailable; and third, since the miner in this case did not die prior to March 1, 1978 and the Claimant did not file her claim for survivor's benefits prior to June 30, 1982, the Section 718.306 presumption is likewise unavailable to her.

The final method of establishing the presence of pneumoconiosis is through a reasoned medical opinion, offered by a physician exercising sound medical judgment, pursuant to Section 718.202(a)(4). The narrative medical reports of record have been previously set out in this decision. Specifically,

Section 718.202(a)(4) provides:

> "A determination of the existence of pneumoconiosis may also be made if a physician, exercising sound medical judgment, notwithstanding a negative x-ray, finds that the miner suffers or suffered from pneumoconiosis as defined in § 718.201. Any such findings shall be based on objective medical evidence such as blood-gas studies, electrocardiograms, pulmonary function studies, physical performance tests, physical examination, and medical and work histories. Such a finding shall be supported by a reasoned medical opinion."

The record in this case contains the medical opinions of eleven physicians. However, Drs. Gardberg, Dutt, Iyengar, Bansal and Boyer offered no opinion on the issue of pneumoconiosis. Dr. Gardberg treated the miner solely for gastroenteritis and chest pain on one occasion in 1975. He conducted only a physical exam and EKG and his only reference to the miner's respiratory health is a notation that his lungs were clear to auscultation. Dr. Dutt's patient progress notes are vague and difficult to read, with no reference to coal mine employment, smoking history, or respiratory disease. These records are dedicated almost entirely to the miner's heart problems with some references to macroglobulinemia. Dr. Iyengar's treatment notes indicate that he saw the miner in follow-up of his cardiac status post coronary artery bypass surgery and resulting complications. Although his notes reflect that he performed a physical examination of Mr. Nogosky, which included listening to his lungs, there was no pulmonary function testing performed and the focus of these notes is on the miner's worsening cardiac condition. Finally, Dr. Boyer apparently saw Mr. Nogosky in consultation with Dr. Bansal and is the surgeon who performed the bypass graft and valve replacement. It appears that there was some pulmonary evaluation performed; for example, he refers to chest x-rays and blood gas analyses performed in 1993 and he noted "basilar crackles in the right lung and decreased lung sounds on the left." (DX 27) He also noted persistent left pleural effusion following surgery, for which the miner underwent draining and diuretic therapy. However, Dr. Boyer's diagnoses were all cardiac-related and he attributed the miner's complaints of shortness of breath to "his chronic obstructive pulmonary disease...." **Id.** However, this diagnosis of COPD cannot suffice as a diagnosis of

pneumoconiosis because there is no reference in Dr. Boyer's notes to the miner's smoking or work histories; therefore, as he did not attribute the COPD to the miner's exposure to coal mine dust, it does not meet the legal definition of CWP. Similarly, Dr. Bansal's records all refer to the cardiac problems Mr. Nogosky was experiencing, along with some references to bone marrow biopsies in connection with his macroglobulinemia. In summary, all of these physicians appear to have treated the miner for other conditions unrelated to his coal mine employment. Not one doctor made any reference to his exposure to coal dust as a factor in his various medical problems and, therefore, do not support a finding of CWP. I turn now to the remaining medical opinions of record.

Of the six remaining physicians whose opinions are in the record, two physicians (Drs. Guarda and Perper) concluded that the miner did not suffer from CWP, three (Roll, Goldman and Akula) were equivocal, and one (Dr. Covelli) made a positive diagnosis of CWP. For the following reasons, I find that the three doctors who failed to either rule in or rule out a diagnosis of CWP, do not offer sufficient reasoning to hold that their opinions constitute evidence that the miner had an occupational dust-related lung disease which contributed to his death. Despite the fact that Dr. Roll, who holds no Board-Certification in Pulmonary Disease, but listed this as a self-designated specialty on his curriculum vitae, was consulted in 1973 for the purpose of determining whether the miner had black lung, he made no such determination. Rather, Dr. Roll could only state that a chest x-ray taken at that time revealed interstitial fibrosis *"which could conceivably be pneumoconiosis...but is not characteristic of it."* (DX 17)(Emphasis added) At this time he also noted an abnormal EKG and stated that Mr. Nogosky had "moderately reduced function." Whether he was referring to cardiac function, lung function, or some overall assessment of the miner's level of disability, is unclear. This type of opinion, which hedges on the central issue of this case (the presence of pneumoconiosis), has very little probative value, as Dr. Roll fails to draw a connection between the miner's pulmonary condition and his work history, of which he was aware. I therefore accord very little weight to this report.

For similar reasons, the reports of Drs. Goldman and Akula likewise provide little probative value on the issue of the existence of pneumoconiosis in this miner. Dr. Goldman, who saw

the miner in 1980, conducted a pulmonary evaluation which included physical examination, chest x-ray, spirometry and blood gas analysis. He made a diagnosis of simple chronic bronchitis, which he attributed to the miner's extensive smoking history. He further stated that this condition might possibly have been aggravated by his exposure to coal dust, "but because there is no respiratory impairment...nor any significant abnormalities on chest x-ray, I do not consider him impaired or disabled in any way." (DX 17-49) Apparently, Dr. Goldman was focusing on the extent of the miner's disability and not necessarily on its cause. His equivocation on the subject of what caused his respiratory condition renders his report of little probative value to this Administrative Law Judge. At best, Dr. Goldman thought it possible that coal mine employment may have worsened his simple bronchitis. Dr. Akula examined the miner on two occasions, approximately two months apart, in the spring of 1994. It is somewhat curious that, despite the fact that Mr. Nogosky was being evaluated for shortness of breath, there were no pulmonary function tests or blood gas tests performed at this time. These records indicate only a chest x-ray, physical exam and routine blood tests. Based upon this data, plus the miner's report of a thirty-year, two-pack-per-day smoking history, Dr. Akula diagnosed shortness of breath probably caused by congestive heart failure, "however, underlying obstructive lung disease cannot be ruled out (the patient has a history of smoking about 60-pack years)." (DX 27) This notation suggests that the doctor felt that part of his shortness of breath may be due to smoking-related obstructive lung disease. Perhaps what most diminishes the persuasive weight of this report, is the lack of any detailed work history, other than the statement, "[t]he patient worked in the coal mines for several years, but he was never told to have any black lung." (DX 27 at 325) Without an accurate account of the miner's occupational exposure to coal dust, this physician was in no position to form an educated opinion about whether his impairment was dust-related or not. For this reason, I find this opinion of little merit on the issue of the existence of pneumoconiosis and, for the reasons stated above, I accord little weight to the reports of Drs. Goldman and Akula. I pause to note that both physicians are highly qualified, with Board-Certificates in Internal medicine and Pulmonary Disease; however, without a more definite statement from either doctor regarding the cause of this miner's respiratory impairment at the time of their examinations, their reports are of little value on this issue.

Dr. Covelli, the only physician of record to positively

diagnose coal workers' pneumoconiosis, is Board-Certified in both Internal Medicine and Pulmonary Disease. His examination of the miner in 1981 consisted of a physical exam and review of a chest x-ray taken at that time. He concluded that the miner had CWP based on his findings of an underground mining history of 45 years, "occasional expiratory rhonchi over both lungs posteriorly" and evidence of "pneumoconiotic process over both mid to lower lung fields. There is a very mild obstructive ventilatory pattern despite discontinuation of tobacco in 1965. As such, I feel his symptoms of dyspnea are related to his coal dust exposure." (DX 17-50) There are several problems with Dr. Covelli's analysis. First, he did not have an accurate smoking history of this miner. He reported only a one-pack-per-day habit ending in 1965, with no mention whatsoever of his four-pipe-per-day habit with inhalation which continued until and beyond the time of this exam. Second, Dr. Covelli diagnosed a mild obstructive ventilatory defect; however, there is no indication that he conducted a pulmonary function study and I am at a loss as to how such a finding was made on the basis of a chest x-ray and physical exam alone. Third, the record indicates that the miner worked in the mines for approximately 35 years, minus 4½ years while serving in the military. Furthermore, Mrs. Nogosky testified at hearing that they moved to Florida in 1969 to get away from the mines. Therefore, it is impossible, contrary to what Dr. Covelli's report states, that the miner was still working in the mines in 1981 or that he had a 45 year history of such. Finally, the chest x-ray upon which Dr. Covelli appears to base much of his opinion was also interpreted by Dr. Sargent, who holds superior qualifications to Dr. Covelli, who is neither a B reader nor Board-Certified in Radiology. Dr. Sargent interpreted this film as completely negative for CWP and, as I stated earlier, I accord his opinion greater weight in this regard, given his superior qualifications for x-ray interpretation. For these reasons, I find that Dr. Covelli's opinion that Mr. Nogosky suffered from CWP is seriously damaged by the inaccurate information upon which he relied. It is impossible to know what Dr. Covelli would have concluded had the miner's smoking history not been diminished and the work history not been exaggerated. As a result, his opinion holds little persuasive weight and I find and conclude that it is insufficient to satisfy Claimant's burden of establishing that her husband suffered from coal workers' pneumoconiosis prior to his death.

This leaves the two opinions of the pathologists, Drs. Guarda and Perper, who both concluded that Mr. Nogosky did not

have CWP at the time of his death and who both hold similar professional qualifications. As the burden rests with Claimant to affirmatively establish the existence of the disease, it is not necessary to evaluate these physicians' reports for their sufficiency to *disprove* the presence of CWP in this case. However, I note that both pathologists, especially Dr. Perper, explained in detail how their findings of anthracotic pigmentation did not rise to the level of a finding of pneumoconiosis and how the miner's death was wholly attributable to his escalating heart disease and complications which arose therefrom. There is ample support in the record for the conclusion that the miner's cardiac status continued to deteriorate after his coronary bypass surgery, although he experienced periods of temporary improvement, prior to his demise. Therefore, even if one could conclude that Dr. Covelli was correct and there was evidence of pneumoconiosis as early as 1981, which I have expressly ruled against, there is no evidence whatsoever, that such condition caused, contributed to, or hastened his death in any way.

**CONCLUSION**

The regulations clearly state that survivors are not eligible for benefits where the miner's death was caused by a traumatic injury or the principal cause of death was a medical condition unrelated to pneumoconiosis. 20 C.F.R. § 718.205(c)(4). Such is the case here. Mr. Nogosky died as a result of his multiple cardiac problems, none of which the evidence suggests were caused or aggravated by his occupational exposure to coal dust.

**ENTITLEMENT**

I have determined based upon all of the evidence of record, that Claimant has failed to proffer sufficient probative evidence that the miner suffered from coal worker's pneumoconiosis, or that it could have hastened the miner's death in any way. Therefore, Mrs. Nogosky is not entitled to survivor's benefits under the Act, as she has failed to prove an essential element of her claim.

**ORDER**

It is hereby **ORDERED** that the claim of Maxine B. Nogosky for survivor's benefits under the Act is **DENIED.**

A
**DAVID W. DI NARDI**
District Chief Judge

Boston, Massachusetts
DWD:km

**NOTICE OF APPEAL RIGHTS**

**Pursuant to 20 C.F.R. § 725.481, any party dissatisfied with this Order may appeal it to the benefits review Board within thirty (30) days from the date of this order by filing a Notice of Appeal with the Benefits Review Board; U.S. Department of Labor; Room S-5220, FPB; 200 Constitution Avenue, N.W., Washington, DC 20210; ATTN: Clerk of the Board. A copy of this Notice of Appeal must also be served on Donald S. Shire, Esq.; Associate Solicitor for Black Lung Benefits; U.S. Department of Labor; Room N-2117, FPB; 200 Constitution Avenue, N.W.; Washington, DC 20210.**